State of Rhode Island and Providence Plantations
Department of Administration
Division of State Employees Workers' Compensation
One Capitol Hill
Providence, Rhode Island 02908-5866

Authorization for Release of Confidential Information

Claimant's Name:

Date:

Birth Date:

Social Security Number:

I authorize physicians, clinicians, counselors, hospitals, counseling agencies, clinics, etc. and all attendants thereto to furnish full and complete medical, diagnostic, treatment, Clinical, counseling, service reports and billing records, and other information hereby requested by the DOA/ State Employees Workers' Compensation.

The information being sought is to be used in evaluation of a pending workers' compensation claim. Failure to authorize release of this information may cause a delay in processing that claim.

This authorization is valid until revoked by written request to State Employees Workers' Compensation.

The State Employees Workers' Compensation will not release any information supplied except in accordance with law.

I agree that a photocopy of this authorization shall be valid as the original.

Signed this _____day of _____, 20___.

Patient/Claimant: **Witness:**

_____ _____

Print

_____

Signature

TDD#: 222-2187

Rev:5/2015